

SUPPORT COORDINATOR'S REVIEW OF THE ISP/IFSP

INDIVIDUAL'S NAME (*Last, First, M.I.*)

ASSISTS NO.

ELIGIBILITY

ALTCS TSC DDD (state funded only) Ventilator dependent program (*must send a copy to MCO/Vent RN*)

FREQUENCY

90 Day 180 Day Other: _____

PERSONS PRESENT AT REVIEW (*Please include titles and agency name, if appropriate*)

LOCATION OF REVIEW

DATE OF REVIEW

OTHER TEAM MEMBERS CONSULTED

Name/Title	Agency	Date of Contact

Use the space below to write a narrative that describes (*if additional space is needed, use the DDD-1271A Continuation Page*):

1. Your interactions with the person served. Note significant changes since the last ISP/IFSP and progress toward goals,
2. The individual's/responsible person's view of the individual's progress toward goals/objectives, satisfaction with services and providers and concerns about any unmet needs. Document efforts to acquire needed services and supports,
3. The provider's and other team members' views of the individual progress and concerns about unmet needs,
4. Changes in the person's medical/functional status, such as change in the primary care provider (PCP), doctor's visits or hospitalizations, changes in physician's orders, new evaluations and/or follow-up to previous evaluations/appointments, changes in medications, changes in durable medical equipment, or changes in behavioral health status,
5. If receiving behavioral health services, address how the individual is doing on their behavioral health objective(s)/outcome(s). Please gather information from the individual parent(s)/caregiver, and from conversations with the QBHP/clinical liaison.
6. Note changes in the individual's eligibility since the last review.

Equal Opportunity Employer/Program ♦ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program of activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602 542-6825; TTY/TTD Services: 7-1-1.

7. IF THERE ARE NEW PROFESSIONAL EVALUATIONS, HAS ALL REQUIRED FOLLOW-UP BEEN COMPLETED?
 Yes No N/A

8. HAVE REPORTS FROM SERVICE PROVIDERS REGARDING ALL OBJECTIVES INCLUDING BEHAVIORAL HEALTH AND THERAPIES BEEN RECEIVED?
 Yes No N/A

9. HAS PROGRESS BEEN MADE ON ALL GOALS AND OBJECTIVES?
 Yes No N/A

10. DOES THE INDIVIDUAL RECEIVE THE SERVICES LISTED ON THE ISP REGULARLY?
 Yes No N/A

11. DO SERVICES ON THE ISP/CHANGE IN ISP MATCH THE FOCUS SERVICE PLAN?
 Yes No N/A

12. ARE ALL INDIRECT SERVICES INCLUDING EDUCATIONAL/VOCATIONAL SERVICES ENTERED IN FOCUS?
 Yes No N/A

13. ARE THESE SERVICES (*Direct and indirect*) SUFFICIENT AND APPROPRIATE TO MEET THE INDIVIDUAL'S NEEDS?
 Yes No N/A

14. IF THE INDIVIDUAL IS WAITING FOR SERVICE(S), HAS HE/SHE BEEN OFFERED OR IS HE/SHE RECEIVING AN ALTERNATIVE SERVICE(S)?
 Yes No N/A

15. IF THE INDIVIDUAL IS WAITING FOR SERVICE(S), HAS IT BEEN ENTERED INTO FOCUS?
 Yes No N/A

16. IF THE INDIVIDUAL HAS NOT USED SERVICES IN THE LAST 90 DAYS, ARE ALTCS SERVICES STILL NEEDED? (*Explain in narrative*)
 Yes No N/A

17. ARE SERVICE COSTS LESS THAN 80% OF INSTITUTIONAL CARE?
 Yes No N/A

18. HAVE THE TEAM ASSIGNMENTS ON THE LAST ISP AND SUBSEQUENT REVIEWS BEEN COMPLETED? (*Including notice that service has begun*)
 Yes No N/A

19. IF NEEDED, HAS A REFERRAL BEEN MADE TO THE BEHAVIORAL HEALTH PROVIDER?
 Yes No N/A

20. HAS THERE BEEN A CHANGE IN PBHP/QBHP ASSIGNMENT?
 Yes No N/A Name _____ Title _____

21. HAS THE CORRECT BEHAVIORAL HEALTH CODE BEEN ENTERED IN FOCUS?
 Yes No N/A

22. IF THE PERSON RECEIVES PSYCHIATRIC/PSYCHOTROPIC MEDICATION, IS IT EFFECTIVE AND IS HE/SHE FREE FROM ADVERSE SIDE EFFECTS?
 Yes No N/A

23. IS THE INDIVIDUAL/RESPONSIBLE PERSON SATISFIED WITH THE HEALTH PLAN/PCP (*Primary Care Provider*) AND MEDICAL FOLLOW-UP?
 Yes No N/A

24. IS THE INDIVIDUAL/RESPONSIBLE PERSON ABLE TO LOCATE RESOURCES (*e.g. housing, government benefits, etc.*) WITHIN THE COMMUNITY?
 Yes No N/A Assistance offered/needed (*describe in narrative below*)

25. HAS A RISK ASSESSMENT BEEN COMPLETED/REVIEWED?
 Yes No N/A

26. IF THE PERSON RECEIVES ATTENDANT CARE, HOUSEKEEPING, HABILITATION INDEPENDENT (HAI) OR RESPITE, HAS A BACKUP PLAN BEEN DEVELOPED TO ADDRESS PROVIDER NO SHOWS?
 Yes No N/A

27. HAVE THERE BEEN ANY GAPS IN SCHEDULED SERVICE? (*i.e., provider no showed for a shift*)
 Yes No N/A

If you answered "No" to any of the questions above, explain and record necessary follow-up actions below. (*If additional space is needed, use the DDD-1271A Continuation Page*)

FOR TSC ONLY: DOES THE INDIVIDUAL/RESPONSIBLE PERSON WISH TO MAKE ANY CHANGES IN THE TYPE AND/OR FREQUENCY OF CONTACT

Yes No Type _____ Frequency _____

- ◆ If appropriate, complete a PRE-PAS on TSC or DDD individuals and refer him/her to ALTCS.
- ◆ If changes are needed to the person's ISP as a result of this review, complete and attach DD-224, Change In The ISP.
- ◆ Print the updated Focus Service Plan Screen and attach it to this review in the case file.

SUPPORT COORDINATOR'S SIGNATURE	SUPPORT COORDINATOR'S NAME (<i>Please print</i>)	DATE
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